

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service, 10-22-01.
- b. The request was received on 08/20/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60
 - b. UB-92(s)
 - c. EOB(s)
 - d. Medical Records
 - e. Example EOBs from another Insurance Carrier
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. UB-92(s)
 - c. EOB(s)
 - d. Carrier methodology
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 10-17-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 10-18-02. The response from the insurance carrier was received in the Division on 10/21/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Noted on the Table of Disputed Services:

“reimbursement amount unacceptable-see attached”
2. Respondent: Letter dated 10/21/02

“The dispute in this case is in regard to the Requestor’s entitlement to additional reimbursement for facility charges for services on 10/22/01 for surgery including CPT Code 64510 – Injection, anesthetic agent; stellate ganglion (cervical sympathetic) and CPT Code 20550 – Injection, tendon [sic] sheath, ligament, trigger points or ganglion cyst. The Requestor billed \$2989.43 as a facility fee for these procedures. Respondent, ... has paid \$1017.09 as the ‘fair and reasonable reimbursement’ for these services. The amount in dispute is \$2424.35. The Requestor has failed to establish that its charges or the additional amount of \$2424.35 in dispute complies with the Texas Workers’ Compensation Act or TWCC Rules.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10-22-01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor’s Table of Disputed Services, the Requestor billed the Carrier \$2,989.43 for services rendered on the date above in dispute.
4. Per the Requestor’s Table of Disputed Services, the Carrier paid the Requestor \$565.08 for services rendered on the date above in dispute.
5. The Carrier’s EOBs deny additional reimbursement as “705 M – No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area; 51 – F –Fee Guidelines/Multiple procedures allowance; 5 – G- Unbundling/Reimbursement based on or included in the basic allowance of the appropriate procedure.
6. Per the Requestor’s Table of Disputed Services, the amount in dispute is \$2,424.35 for services rendered on the remaining date above in dispute.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The carrier has submitted documentation asserting that they have paid a fair and

reasonable reimbursement. Respondent has submitted an explanation of their payment methodology. The denial code “G” will not be addressed since this is a facility fee dispute which incorporates all services. The Provider has included example EOBs to support their position.

Per Rule 133.304 (i), “When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
1. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
2. reference its method in the claim file; and
3. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement.”

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), “.... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;”.

Carrier’s methodology incorporates information from 6 states, which have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), which is determined based on where the CPT Code falls in the HCFA intensity grouper list. (Carrier) averaged the payments in each level for the 6 states and designated this as the base fee for each intensity level. (Carrier) also takes into account local economic factors and applies HCFA’s wage index factor to the base fees. If the specific area is not addressed in the wage index, (Carrier) uses the state average.

The Carrier sums up its methodology, indicating it generates fair and reasonable fees utilizing a well accepted intensity grouper and average prevailing usual and customary reimbursement from a geographically diverse set of workers’ compensation fee schedules. There is no discounting from mean payments; a local economic adjustor is applied to the reimbursement; and additional payments are made for extraordinary supplies and lab testing. The Respondent included attachments to further reflect its methodology. Attachment A indicates grouper numbers, CPT codes, and range of charges. Attachment B compares Medicare rates for ASC bills with states that have a similar payment schedule. Attachment C is the wage index used to take into account geographical differences. Attachment D shows samples of Texas ASCs reimbursement. Exhibit 2 reflects a list of ambulatory surgical centers that accept payment based on (Carrier’s) payment methodology.

The Provider has included example EOBs in their dispute packet. The provider has billed under diagnosis code 337.21 (Ref Symp Dyst Upper Limb). The EOBs submitted reflected various ICD-9 codes 353.8, 723.8, 723.4 and 814.00.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. The Respondent has provided their methodology, which conforms to the criteria of Sec. 413.011 (d). However, as the requestor, the health care provider shall provide documentation that "...discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement...." pursuant to TWCC Rule 133.307 (g) (3) (D). The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor's example EOBs are reflective of reimbursements received from other carriers, however, the Requestor fails to define how this information discusses, demonstrates and justifies that the payment being sought represents a fair and reasonable charge for the dates in dispute. The Carrier has complied with Section 413.011 (d), 133.304 (i) and 133.307 (j) (1) (F). Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 21st day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

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